PA15-2004: 2ND OPHTHALMIC ALLERGY MEDICATIONS REQUEST



RI MEDICAL ASSISTANCE PROGRAM PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

PRESCRIBER NAME: PRESCRIBER DEA #: PRESCRIBER DEA #: PRESCRIBER OFFICE ADDRESS: PRESCRIBER NAME: RN/MD/R.PH/PHONE NUMBER: RN/MD/R.PH/PHONE NUMBER: RN/MD/R.PH/PHONE NUMBER: PRESCRIBER: STRENGTH: PRICE PROSING FREQUENCY: DOSING FREQUENCY: DOSING FREQUENCY: PRICE PROVIDED AND AT WEB ADDRESS WAY. GIBS. FEE. 1. GOV/GHS/heacre/provaves/mphaspa.htm HAS THE PRESCRIBER TRIALED THERAPY WITH ONE OF THE PREFERRED AGENTS? YES /NO OPCON-A®, NAPHCON-A®, OR VISINE-A®, (NAPHAZOLINE/PHENIRAMINE COMBINATIONS) IF NO, PLEASE EXPLAIN WHY? HAS THE PATIENT BEEN DIAGNOSED WITH GLAUCOMA IN THE PAST 2 YEARS? YES /NO IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE ICD9 CODE IS THE PATIENT PRESCRIBED MEDICATION TO TREAT GLAUCOMA YES /NO IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT DRUG COMMENTS: PRESCRIBER SIGNATURE DATE By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.	CLIENT NAME:	DOB:	MEDICAID ID NUMBER:
OFFICE PHONE NUMBER ()	PRESCRIBER NAME:		Prescriber DEA #:
OFFICE PHONE NUMBER ()	PRESCRIBER OFFICE ADDRES		
PHONE NUMBER: ()		()	
DRUG REQUESTED: STRENGTH: QTY / FILL: START DATE: DOSING FREQUENCY: DOSING FREQUENCY: DOSING FREQUENCY: START DATE: DOSING FREQUENCY: DOSING FREQUENCY: START DATE: DOSING FREQUENCY: DOSING FREQUENCY: SAVE, ACRE AVAILABLE BY CALLING (401) 784-8100 OR AT WEB ADDRESS NOW, ACRE AVAILABLE BY CALLING (401) 784-8100 OR AT A	•		
START DATE:			the contract of the contract o
HAS THE PRESCRIBER TRIALED THERAPY WITH ONE OF THE PREFERRED AGENTS? OPCON-A®, NAPHCON-A®, OR VISINE-A®, (NAPHAZOLINE/PHENIRAMINE COMBINATIONS) VASOCON-A® (NAPHAZOLINE/ANTAZOLINE COMBINATIONS) IF NO, PLEASE EXPLAIN WHY? HAS THE PATIENT BEEN DIAGNOSED WITH GLAUCOMA IN THE PAST 2 YEARS? YES / NO IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE IS THE PATIENT PRESCRIBED MEDICATION TO TREAT GLAUCOMA YES / NO IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT COMMENTS: PRESCRIBER SIGNATURE DATE DATE			~
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IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE IS THE PATIENT PRESCRIBED MEDICATION TO TREAT GLAUCOMA IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT COMMENTS: PRESCRIBER SIGNATURE DATE	 OPCON-A[®], NAPHC VASOCON-A[®] (NAF 	ON-A [®] , OR VISINE-A [®] , (NAI PHAZOLINE/ANTAZOLINE CO	HAZOLINE/PHENIRAMINE COMBINATIONS)
IS THE PATIENT PRESCRIBED MEDICATION TO TREAT GLAUCOMA IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT COMMENTS: PRESCRIBER SIGNATURE	HAS THE PATIENT BEEN DIAG	NOSED WITH GLAUCOMA IN	THE PAST 2 YEARS? YES / NO
IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT COMMENTS: PRESCRIBER SIGNATURE	IF YES, PLEASE LIST THE AP	PROPRIATE ICD-9 CODE	ICD9 CODE
COMMENTS: PRESCRIBER SIGNATURE	IS THE PATIENT PRESCRIBED	COMA YES / NO	
Prescriber SignatureDate	IF YES, PLEASE INCLUDE THE	E NAME OF THE DRUG PRODU	T Drug
	COMMENTS:		
By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.	PRESCRIBER SIGNATURE _		DATE
	By Signature, the Prescriber	confirms the criteria information a	pove is accurate, verifiable by client records and available for review upon request.

FAX OR MAIL TO: FAX NUMBER 1-800-390-0109

 $\begin{array}{c} \textbf{Heritage Information Systems} \\ \textbf{Attn: RI Prior Authorization Unit} \end{array}$

PO Box 25719 Richmond, VA 23286-8212

TELEPHONE NUMBER 1-866-420-3874

CALL CENTER HOURS
MONDAY — FRIDAY 9:00 AM — 6:00 PM (EST)
FAX Number 1-800-390-0109 (Available 24 hours)